DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4125 (Rev. 01/03)

STATE OF WISCONSIN
s. 252.10 (7), Wis. Stats.
(608) 266-9692
FAX: (608) 266-0049

ANTITUBERCULOSIS THERAPY PROGRAM

FOLLOW UP ON THERAPY

Complete and return this form when the client completes a recommended course of therapy or discontinues treatment. Completion of this form is required. Failure to complete all information requested on this form may affect future medication requests.

Client Name & Address	Physician Name, Address, & Telephone Number (Include area code)
Client's Date of Birth (mm/dd/yyyy)	Local Health Department Name
Date Medication First Ordered (mm/dd/yyyy)	

COMPLETE ITEMS BELOW

1. Client completed therapy after _____ months of treatment.
2. Client did not complete an adequate course of therapy because:
   - ☐ Client died.
   - ☐ Client moved. New address _____
     Client referred to other LHD. ☐ Yes ☐ No If yes, specify name: _____
   - ☐ Client lost to follow up, unable to locate.
   - ☐ TB infection ruled out / follow-up skin test negative.
   - ☐ Client decided to stop taking drugs after ____ months. Give reason if known _____
   - ☐ Therapy discontinued on medical advice due to:
     ☐ Adverse reactions (life-threatening) ☐ Other medical reason, specify: _____
3. Letter sent to physician notifying him/her of client's status. ☐ Yes ☐ No

Other comments _____

SIGNATURE - Person Completing Form _____ Date Completed _____

Print Name _____ Telephone Number (include area code) _____

Return to: Wisconsin Division of Public Health
TB Program, Room 318
P.O. Box 2659
Madison WI 53701-2659